IMPROVING THE PERFORMANCE OF PUBLIC HEALTH AND PERSONAL HEALTH SERVICES: INVESTING IN HEALTH SYSTEM CAPACITY

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1. Introduction:
   - Aims of chapter: how empower and strengthen health system to deliver cost-effective interventions (and achieve risk protection)? What instrument of policy can be used?
   - Key target groups?
   - Main topics
   - Key messages

2 Improving performance: what does it mean?
- Allocative efficiency (cost-effectiveness; cost-benefit)
- Technical efficiency
- Risk protection
- Equity

Performance can be analysed and understood at different levels; include comments on problems of doing this including lack of systems for collecting population data
- Country
- Health system
- Institutions/providers

What do we know about these?
- Country performance: short case studies of sharply differing country performance
- Health system performance literature (very weak):
  - OECD evidence
  - WHO ranking
  - RAND (Tom Croghan – Ecuador, Bangladesh, Egypt)
  - avoidable mortality literature
  - examples of successful investments in system capacity? (Ghana is opposite – decade of health system reform not producing results; health SWAPS have little to show); IMCI successful when health system addressed?
- Organisational performance literature (draw on Hensher; Preker)
- Success stories chapter

2. Background: History and Current Themes
   - Historical context – vertical disease control; primary health care; selective primary health care; essential packages; MDGs; GFATM; health system constraints to scaling up; equity versus efficiency arguments and essential packages versus patient focused care (Segall, Unger et al etc); highlight that changes have often not taken into account strengths and weakness of previous systems - the consequences likely to have been underutilisation/discontinuity of capacity built and lack of attention to core issues central to performance of systems, service utilisation and connections with health outcomes.
   - Differences between health systems and disease control approaches in how they address system problems; failure to address outcomes in SWAPS, health system strengthening programmes of 1990s (too much focus on processes not outcomes)
   - Disease programmes deal with system weaknesses by funding it – then get duplication
   - current theme in MDG literature on health: poor overall relationship between health expenditure and health outcomes, but increased health expenditure improves health if right policies adopted. What are 'right policies'? What are effective implementation processes? Time to reflect on what we have learnt and ensure that that this informs current prescriptions.

3. Health system constraints to delivery of public health and personal health services: evidence (draw from Mills and Hanson special issue of JID; disease programme specific reports eg from Stop TB)

4. Analysis of 'best buys' at different levels (based on DCPP service chapters), plus what other functions those levels perform (eg management, training etc). Pushing down versus pushing up levels of care (generally former, but for delivery might be latter); need to distinguish by eg population density; pc GNP; dr/population.

Importance of effective delivery for determining whether interventions cost-effective in practice – delivery approach is integral part of intervention; CE calculations assume health system exists – therefore potentially misleading where this is not true

5. Address key functions/areas that need strengthening/addressing, based on chapters:

- Priority setting (including addressing patients' perspectives).
- Leadership skills (local, national, international) towards i) needs-based programming; ii) assessment of options for sustainability, iii) efficient and equitable allocation of resources, iv) planning for equity .
- Financing (public/private; compulsory risk pooling versus individual choice);
- Organisational structure (including locus of control over decisions: push down)
- General management functions: finances, HR, consumables, services, HMIS etc (clear accountability; performance-based management; career development); resource allocation (balance between levels of care; balance public health/personal preventive services/curative care (very brief; refer to Ramanan chapter))
- Human resources quantity and quality
- Essential drugs/diagnostics and other consumables procurement, and supply management (and distribution)
- Quality assessment and assurance
- Regulation/stewardship
- Inter-sectoral action
- Information for decision making (health and management) strengthening as a core national resource for needs-based resource allocation and programme planning (Need Norms box fit in here?); opportunities stemming from advances in (a) IT and (b) communication technology
- Monitoring and evaluation processes and systems (including pop-based health surveillance systems for health outcomes and evaluation of interventions)
- Methods to increase transparency of resource allocation and accountability of services to communities; user voice.

6. Implementing a rationing/targeting approach: options and evidence of effects (check Xingzhu WHO/WB paper on achieving allocative efficiency)

Systems level:

- Explicit rationing of provision of care in public and private sectors; involving users in prioritisation
- Marginal budgeting for bottlenecks
- Constraining resource envelope and leaving to clinical decisions (Segall)
- Training health workers plus continuing education (Unger et al: adverse effects)
- Financial incentives to providers and users (eg public funding only for priority interventions); evidence from eg GP incentives in UK (Scott and Hall '95; Scott 96)?
- Contracting providers for specific services with monitoring of disease/intervention targets (eg immunisation coverage)

Service delivery level:

- Provision of information for local planning (eg TEHIP approach)
- Quality assurance methods including provision of information to providers; self regulating providers
- 'results orientated management' (Berwick 2004); New Public Management (WB); give freedom to managers to manage
- user voice

7. Balance of horizontal and vertical approaches (Oliveira-Cruz et al; Unger et al); what is appropriate for what intervention and what setting (eg spraying needs hierarchical approach) China eg of mix: disease control vertical programme bought time from health service operational staff

8. Increasing absorptive capacity: approaches
   - How to help countries absorb major increments in funding disease control

9. Solutions in low capacity environments
   - Strong leader? (more managerial approach not possible)
   - Use of NGOs
   - Campaign approach eg immunisation and ITN campaigns
   - community directed treatment
   - building for the long-term: draw experience from vertical programmes to build up services (Pakistan: PHC built on TB/.leprosy clinics); over time categorical programmes become more advisory; less managerial

9. Research priorities
   - cost of the system
   - etc

10. Conclusions
    - vital and urgent need to address underperformance of health systems
    - need to hold strengthened systems accountable for improved health outcomes – achieve the best of both health systems strengthening philosophies and disease control philosophies
    - key messages on how to do this: eg
      - strengthen capacity to deliver PHC and first level hospital care
      - strengthen health systems through disease control programmes
      - health information system developments needed
      - quality improvement